STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
18-20 TRINITY STREET, HARTFORD, CONNECTICUT 06105

Sarah Healy Eagan
Acting Child Advocate

TESTIMONY OF THE OFFICE OF THE CHILD ADVOCATE FOR THE STATE OF CONNECTICUT

COMMITTEE ON CHILDREN
MARCH 9, 2021

Senator Anwar, Representative Linehan, Senator Martin, Representative Dauphinais, and all distinguished members of the Committee on Children, this testimony is being submitted on behalf of the Office of the Child Advocate ("OCA") in support of the following Bills. The obligations of the OCA are to review, investigate, and make recommendations regarding how our publicly-funded state and local systems meet the needs of vulnerable children.

SB 2 AN ACT CONCERNING SOCIAL EQUITY AND THE HEALTH, SAFETY AND EDUCATION OF CHILDREN.

Section 1. QPR Training OCA and Youth Suicide Advisory Board

OCA supports the goals of these sections, which seeks to train and inform community members and licensed health professionals regarding suicide prevention. Such training is essential to combat the growing numbers of children who seek to end their own lives. OCA looks forward to partnering with this Committee and other necessary stakeholders, in particular our colleagues at the Department of Mental Health and Addiction Services and the Department of Children and Families—the current co-chairs of the State's Suicide Advisory Board—to ensure this legislation is well positioned to build on existing initiatives regarding suicide prevention training.

Attention to suicide prevention activities, always a crucial public health priority, is as urgently needed as ever, given the emotional burdens that have impacted our children during COVID-19. As it is, suicide is the second leading cause of death for children over age 10, following only motor vehicle crashes. Universal suicide prevention screening being done at Connecticut Children's in the past two years has shown, during COVID-19, and increase in the percentage of youth reporting despair and thoughts of suicide. In fact, during recent months, more than 20 % of youth coming to the hospital for medical or mental health reasons have screened "positive" on suicide prevention screening tools. This is a public health crisis right now.

Suicidality and despair are a growing phenomenon among children

Between January 2001 and December 2020, Connecticut has lost 175 children to suicide. Boys accounted for more than 60 % of those suicide deaths. For the past 8 years however, girls have been dying at an increasingly similar rate to boys. Youth suicide has a devastating impact to the youth's family, school, and community, and the ripple effect of each tragedy cannot be overstated. A death from suicide is a death like no other, as it may carry shame, stigma, and concerns for contagion.

Centers for Disease Control's Survey—Connecticut Data on Youth Suicidality and Despair

The CDC health survey has been administered in Connecticut since 2005. Below are excerpts from the most recent report:

18.4 % -- The percentage of youth in grades 9 through 12 who responded yes to the question of whether they had done something to purposely hurt themselves without wanting to die. Hispanic youth now lead this category with affirmative responses.

26.9% -- The percentage of youth who responded that they had felt sad or hopeless for more than two weeks during the previous year. More than 1/3 of girls participating in this survey answered "yes." Of those answering yes to this question, only a quarter of those youth stated that they got the help that they needed, *a decrease* of 14 percentage points since 2005.

13.5% -- The percentage of youth who responded that they had seriously contemplated attempting suicide in the previous 12 months. Girls of color now lead this category.

8.1% -- The percentage of youth who responded that yes, they had tried to attempted suicide in the previous 12 months. Black youth recently led in this category.

Connecticut Suicide Advisory Board (CTSAB)

DCF and DMHAS co-chair this body composed of state officials, community-based providers and advocates, and suicide attempt and loss survivors. The CTSAB examines and promotes evidence-based suicide prevention curriculums. The mission of the CTSAB is described here: https://www.preventsuicidect.org/resources/training/, and is embodied in its 1 Word, 1 Voice, 1 Life campaign.:

The CTSAB emphasizes the following on its website:

In order to prevent suicide, it is imperative that lay persons up through professionals gain the knowledge and practice to become competent in identifying individuals at risk of suicide and connecting them to help, just as with First Aid.

Through the efforts of the CTSAB, Connecticut has various curricula for suicide prevention already utilized throughout the state, including **Question Persuade Refer** (QPR), **Signs of Suicide** (SOS), **Applied Suicide Intervention Skills Training** (ASSIST) and others**.** These curricula are designed for various target populations. **QPR** is the most popular and relevant of the trainings, since it is for the general population and can be completed in about two hours. It is known as the "CPR" of behavioral health. Over the years, DCF, the Child Advocate's Office, and the CTSAB has funded or performed numerous prevention trainings and several **QPR** train-the-trainer programs.

The CTSAB authored the state's Strategic Plan for Suicide Prevention, which emphasizes the need for community-based training to promote youth wellness and reduce youth suicide risk.

No specific state appropriation for suicide prevention work beyond federal grant dollars

Despite the critical nature of the collaborative' s mission, the work of the CTSAB is entirely supported by federal grant dollars. This work receives *no specific state line item.* It may be worth considering that similar work going on in the neighboring state of Massachusetts receives a 4 million dollar line item appropriation.[1] Funding would go a long way to helping state and local leaders scale up suicide prevention programs and training.

OCA Recommendations for Section 1

1) The State should provide a specific appropriation for this work to support critical community training efforts, with dollars available to the state agency co-chairs of the CTSAB to implement the goals of this legislation.
2) The OCA is not staffed or funded to facilitate the provision of the bill, but OCA does participate in the CTSAB and can consult with the CTSAB chairs on the work described herein. The CTSAB can report back to the Committee regarding progress with these important provisions.

Sections 11, 12 and 13- Educator Professional Development Address Social Emotional Learning.

Sections 11, 12 & 13 – pertain to social-emotional learning. The first integrates social-emotional learning throughout the professional development series for certified staff. The second section requires each school district's Professional Development and Evaluation Committee to include social-emotional learning in the district professional development plan for certified employees of the district. Lastly section 13 requires the integration of social-emotional learning in the local district's

[1] https://budget.digital.mass.gov/bb/h1/fy19h1/brec_19/act_19/h45131026.htm. 2019 saw a MA line item of 4.01 million dollars for the state's Suicide Prevention and Intervention Program, including the provision of statewide and community-based suicide prevention, intervention, post-intervention and surveillance activities.

education goals for the district. OCA supports the incorporation of these critical subject matters into districts' professional development frameworks.

Section 14 - Remote parent teacher conferences
Section 14 – OCA supports this provision which will enable more parents and guardians to engage with educators for parent teacher conferences.

Section 15 -- Information from school district on community resources
Section 15 – requires the SDE to develop a document for use by local and regional boards of education that provides information concerning safety, mental health and food insecurity resources and programs available for students and their families. OCA strongly supports the regular dissemination of helpful, user-friendly information to students and their families as to how they can access help for unmet needs.

Section 23 -- Careline Texting
Section 23 requires DCF to develop a system for its child abuse and neglect hotline (Careline) to receive reports via text. OCA is supportive of strategies to increase reliability and feasibility of reports of suspected child abuse or neglect, but OCA does not support a provision to require DCF to accept texted reports at this time. It is not clear that text messaging permits reliable transmission of necessary information that will enable DCF to screen and review reports of concern about a child. DCF's testimony today refers to the work they are doing to create an online referral portal, accessible to mandated reporters, and the improvements in Careline/reporting wait times.

OCA does think that the reliability and functioning of the DCF Careline is of critical public importance, and OCA is aware that DCF is currently examining and strengthening its continuous quality improvement framework for this essential agency function. The Careline is the "Emergency Department" of DCF, where concerns are heard, screened, triaged, and directed for further response (or not). It is imperative that the Careline is highly functional, accessible, and making reliable and timely decisions to ensure children's safety and wellbeing.

OCA Recommendation on Section 23
Referencing early recommendations made by the OCA, as DCF looks to streamline its legislative reporting requirements (which OCA supports), and the long-time federal consent decree binding Connecticut's child welfare department is likely to end in this biennium, OCA suggests that the Committee conduct an annual informational hearing (or two) with DCF, and outline a series of topics about which members will be briefed, including critical DCF functions: 1) Reliability and efficacy of the Careline; 2) Quality of DCF investigation work; 3) Strategies to Assess and Ensure Children's Safety; 4) Prevention and Response to Critical Incidents Involving Children; 5) Permanency Outcomes for Children Involved with DCF; and 6) Implementation of the DCF-led Behavioral Health Plan. OCA is available to participate in and support such a hearing and can contribute information regarding OCA's function and activities as they relate to the child welfare system and child fatality prevention.

Section 24 Considered Removal Letter

Section 24 requires DCF, when considering removing a child from his or her family home, to send written notice to the parent or guardian. When it is believed that a child cannot remain safely at home, the Department conducts a "considered removal meeting" to establish a plan to address the safety concerns identified that have a raised the specter of child removal, and to see how these safety concern/s can be mitigated through services and personal/relative supports. In essence, the proposed language codifies a notice requirement with regard to the "considered removal meeting." At present, DCF staff calls the parents or guardians to notify them of the meeting and encourages them to invite extended family members or other family supports. Attorneys for the parents or guardians and the child are also invited if participants are already represented by counsel.

DCF's testimony provides that "if a considered removal meeting could not be held prior to removal, it was due to immediate danger requiring that child to be protected. However, the family is invited to a considered removal meeting after placement to determine if supports can be implemented to have the child returned home immediately. Written notice would delay this process and could cause the child to either remain in a harmful situation or to remain in care longer than necessary."

OCA generally supports the concept of written notice and formal notice requirements whenever feasible, as it is essential to afford fair process to parents and guardians. However, OCA does give deference to the cautions DCF raises about the notice requirement. It would be useful to better understand the concerns that led to this raised provision so that stakeholders could strategize about the most effective way to address those concerns and provide fair process to the parent/guardian without compromising children's safety. It is important to underscore that a removal is only considered when a concern about the child's safety in the home has been identified by DCF during its investigation, using both social work judgment and a research-based safety tool. Safety concerns include, but are not limited to:

1. Caregiver caused serious physical harm to the child.
2. Sexual abuse is suspected.
3. Substance abuse seriously impairs safety of child.
4. Domestic violence in the home poses serious risk to child.

Moreover, most Considered Removal Meetings result in mitigation of safety concerns, though not all.

Section 26: Birth to Five Services

OCA supports the concept of extending the state's Birth to Three services to four and five year olds. There is so much that is innovative, effective, and family-friendly in the Birth to Three model that frankly should inform so much more of our service delivery system for children with disabilities or mental health treatment needs. Many parents, and children, are hesitant or concerned about the transition from early intervention to public school services. Birth to Three providers are trained to work with the family and child together, provide services in the natural environment, identify goals and objectives with the regular input of the family, and provide multi-disciplinary services to support the "whole" child in the context of his or her family. Let me state unequivocally, we need a lot more of that approach in our system, and if we had it, families and children would be better off, and we

would prevent inefficiencies and waste down the road. OCA has long been concerned about the following:

1. Lack of continuity for children exiting the Birth to Three system;
2. Loss of services and supports for families with children that do not qualify for special education service delivery;
3. Lack of robust services on the preschool special education side for children, depending on where they live and what school system they are part of;
4. Lack of care coordination for children transition from or exiting Birth to Three;
5. Loss of parental training and support services for families who have children with disabilities;
6. Loss of services provided in the child's natural environment: home and community settings, making it harder for supports to be aligned and for children to generalize new skills across their environments.

We can do better.

Are we ready now to extend this service delivery system? Probably not. The legislature recently created a task-force (P.A. 19-184) to look at ways to improve transition supports and outcomes for children leaving Birth to Three. The taskforce made several recommendations, including:

1. Require an ASQ be completed for students found not eligible for Part B.
2. Encourage all communities to create an early childhood liaison position.
3. Consider additional data collection for monitoring children found not eligible for Part B services.
4. Monitor collaboration between community-based programs and LEAs specifically with regard to referrals of children who had received Birth to Three and found not eligible for Part B services.
5. Allow families who have children turning 3 in the months from May to August to choose to remain in their current Birth to Three programs until the start of the following school year or receive services from the LEA through Part B. This would require additional fiscal resources.

OCA Recommendations on Birth to Three

The legislature could do the following:

1. Monitor progress of the recommendations from the Birth to Three transition task-force;
2. Reconvene the Taskforce with the express goal of examining how to extend services for children through age 5 and offer care coordination services to children whose families transition to public school special education services;
3. Re-charge the Taskforce to look specifically at inequities/disparities in the early childhood special education system and develop recommendations to remedy these concerns for the legislature.

4. Ensure that federal education stimulus dollars are specifically utilized by districts to support the needs of early childhood education/special education students, and that SDE is closely monitoring the needs of this population.
5. Implement strategies with new federal stimulus/support dollars to allow families to extend Birth to Three services for a period of time (12 months) who would otherwise transition out of early intervention, and study the efficacy of these extended services for improved developmental and academic outcomes.

Section 45 - Children's Taskforce

Section 45 establishes a task force to study the needs of children. Please know that OCA is always a resource to support such task forces and contribute our perspective as the state's independent oversight agency for children and co-chair of the State's Child Fatality Review Panel.

Additional OCA Recommendations for Children Age Birth to Five

While Connecticut is home to many services that support infants and their parents, we continue to lack a state-led strategic plan for ensuring all infants and very young children have their basic needs met for health care, housing, and related supports, disproportionately impacting pregnant women and young children of color. Families with children are more likely to report having been evicted, or being unable to pay for housing. Thousands of Connecticut children struggle with persistent hunger, and Connecticut's infant mortality rate for babies born to black women remains higher than the national average. (Datahaven, *Towards Health Equity in Connecticut: The Role of Social Inequality and the Impact of COVID-19****; Infant Mortality Rates by State, 2018, Centers for Disease Control***).

Infants and toddlers are also the most likely to be critically injured due to maltreatment or accidental injury, and post-injury or fatality investigations often reveal that families were struggling with multiple stressors, including unmet economic, social and mental health treatment needs. While our state agencies continue to innovate to meet the ever-shifting demands of the pandemic, COVID-19 has worsened these persistent concerns, and highlighted the urgent need to strengthen essential services for caregivers and young children.

REC 1: INCREASE ACCESS TO HOME VISITING NOW.

Home visiting services, facilitated by the Office of Early Childhood, are low-cost and effective. They benefit children by reducing infant mortality, improving child development, and reducing incidents of abuse and neglect. We are not close to meeting the level of need for home visiting in this state. We can help right now and take a step towards universal home visiting access by increasing funding for these services, ensuring that all new babies/parents are offered at least two home visits, and incorporating home visiting and infant/toddler-mental health services into our state Medicaid Plan. We should see if federal stimulus dollars can be steered towards enhancing and scaling home visiting supports and ameliorating harms created by the pandemic for caregivers with young children.

REC 2: STATE AGENCIES SHOULD OUTLINE THEIR SPECIFIC PLANS TO HELP PREGNANT WOMEN, INFANTS AND YOUNG CHILDREN.

Legislators can ensure that existing and proposed budget proposals regarding Medicaid, housing support, food distribution, etc., include specific plans to address the needs of pregnant women and young children during and post-COVID-19. State agencies can report regarding how they are supporting pregnant women and caregivers with young children, including babies born during the COVID-19 pandemic, what gaps exist that they are most concerned about, how agencies are collaborating to address these concerns, and what federal dollars are available to enhance services and outcomes for caregivers and young children now and going forward.

REC 3: IMPLEMENT A STRATEGIC PLAN FOR BIRTH TO FIVE/ FAMILY SERVICES.

Legislators could require a strategic plan from DSS, OEC, DCF, DOH, for ensuring a comprehensive system of support for children birth to five and their parent/s, with a legislative task-force to support the work:

a) The Plan should specifically address recovery supports for parents with infants and young children during and post-COVID.

b) The Plan should also include goals for ensuring all children age birth to five and their families, within a specific time frame, have access to:

- Health care;
- Home visiting and early childhood mental health supports (e.g., Child First);
- Affordable child care;
- Stable housing;
- Parenting supports and interventions for women who are pregnant or parents who have young children and are experiencing health-impacting concerns including interpersonal violence, or mental health and substance use treatment needs.

c) The State Plan should outline existing and potential state and federal funding streams, including entail changes to the State's Medicaid Plan, and how agencies will collaboratively maximize efficient acquisition and use of dollars to reach the state's strategic goals.

d) State Plan must be data driven and focused on equity. Progress towards goals should be reviewed and reported regularly to the legislature, with accompanying data. All data, including health outcomes, should be broken out by region/race/ethnicity.

e) Facilitation of the State Plan and progress can be coordinated by the Connecticut Office of Health Strategy.

Respectfully submitted,

Sarah Healy Eagan, JD

Acting Child Advocate